Better Care Fund planning template – Part 1

Please note, there are two parts to the template. Part 2 is in Excel and contains metrics and finance. Both parts must be completed as part of your Better Care Fund Submission.

Plans are to be submitted to the relevant NHS England Area Team and Local government representative, as well as copied to: NHSCB.financialperformance@nhs.net

To find your relevant Area Team and local government representative, and for additional support, guidance and contact details, please see the Better Care Fund pages on the NHS England or LGA websites.

1) PLAN DETAILS

a) Summary of Plan

Local Authority	**Islington**
Clinical Commissioning Groups	**Islington CCG**
Boundary Differences	**Co-terminus**
Date agreed at Health and Well-Being Board:	**12/02/14**
Date submitted:	**13/02/14**
Minimum required value of ITF pooled budget: 2014/15	**£5,894,000.00**
2015/16	**£18,390,000.00**
Total agreed value of pooled budget: 2014/15	**£5,894,000.00**
2015/16	**£18,390,000.00**

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	Islington
By	Alison Blair
Position	Chief Officer
Date	13 February 2014

Signed on behalf of the Council	Islington
By	Sean McLaughlin
Position	Corporate Director Housing and Adult Social Services
Date	13 February 2014

Signed on behalf of the Health and Wellbeing Board	Richard Watts
By Chair of Health and Wellbeing Board	Council Leader
Date	13 February 2014

c) Service provider engagement
Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it

We have been working with partners over the last eighteen months to develop our plans for integrated care upon which we have based our Better Care Fund submission. We have harnessed the excellent leadership that exists in our local health and care economy so that we remain sighted on the challenges within the sector and develop change through a whole system model. We believe that this commitment to working in partnership both with service providers but also service users and patients has helped us to secure Pioneer Status for our integrated care programme.

Work to date has included workshops with health and social care providers from the statutory and voluntary sector as well as having provider representation on our Integrated Care Board and on work-stream project teams. We hold an annual conference for social care and housing support providers where we have consulted on our plans for integrated care as well as regular meetings through the CCG with health providers, for example, monthly GP forums and the Whittington Transformation Board.

We have strong provider representation not only in planning but also delivery; GP's have been instrumental in supporting the development of a risk stratification tool and leading locality multi-disciplinary teams.

The Council and Whittington Health have Section 75 arrangements and integrated management structures to better co-ordinate and deliver community health care and social services. They have used these relationships to start piloting new ways of working so that we can test and evaluate models as we develop our thinking.

Similarly our mental health services are delivered through pooled budget arrangements with another key provider, Camden and Islington Mental Health Foundation Trust who have been at the forefront of our work to shift care out of secondary health services. They are also supporting us to improve health inequalities by providing more proactive support for physical as well as mental health.

UCH is also a key player who has not only been represented at the Integrated Care Board but has jointly employed a Divisional Clinical Director - Integration with the Whittington to improve links between their acute provision and the local community offer.

The final submission of the plan has been discussed at the Integrated Care Board.

d) Patient, service user and public engagement
Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

From the outset we have been keen to engage with patients and service users and worked with them to develop a set of "I" statements along the lines of those developed by Making it Real. These were crucial in helping us shape our vision and prioritise what was important to the people who receive services.

We have launched a Making it Real Board where we are working with users to develop plans to improve the delivery of care and identify areas of co-production. This Board has been successful in attracting a range of users and carers who can provide different insights from their experience of the health and care system which will be an invaluable resource.

In addition we continue to have a broad offer of patient engagement to inform our progress and check that we are getting it right through integration. Early examples include; a report highlighting the experience of those who have one or more long term condition to inform how we co-ordinate care better; working with women who have used mental health services to identify areas of work – this has informed the Integrated Care plans for Camden and Islington FT; working with local community organisations to identify issues of access to services that has led to us working with GP front of house staff and community pharmacies; using patients and users to undertake peer to peer research into the N19 pilot which is a short term project to test a model for community integration.

Finally, we have patient representation at the Integrated Care Board and have started to develop a communications strategy so that we can have a more streamlined approach to communication with all stakeholders.

e) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	**Synopsis and links**
Islington Joint Strategic Needs Assessment	Sets out the needs of the local population. http://www.islingtonccg.nhs.uk/about-us/jsna
Islington Joint Health and Wellbeing Strategy	Islington's joint strategy to improve health and wellbeing outcomes for our local population. http://www.islington.gov.uk/publicrecords/library/Public-health/Business-planning/Strategies/2012-2013/(2013-03-01)-Joint-Health-and-Wellbeing-Strategy-2013-2016.pdf
Adult Joint Commissioning Strategy	Islington's Joint Commissioning Strategy setting out the strategic direction from 2012-2017 http://www.islington.gov.uk/services/social-care-health/contacts-news-feedback/Pages/Joint-Commissioning-Strategy-Consultation.aspx

Islington Primary Care Strategy	Islington's Primary Care Strategy focuses on driving up the quality of primary care to meet the health needs of the population. It looks at making real improvements in: • GP services – working with the primary care teams • Dental services – general dental practitioners and community dentistry • Community Pharmacy Services – local pharmacists • Optometry Services – local opticians. http://www.islingtonccg.nhs.uk/about-us/strategies/primary-care-strategy.htm
Islington Urgent Care Strategy	This refreshed Urgent Care Strategy again aims to continue to improve urgent care provision from hospital emergency and ambulance services, but also strengthen patient access to urgent care from primary and community services. http://www.islingtonccg.nhs.uk/about-us/strategies/urgent-care-strategy.htm
Islington Care Closer to Home Strategy	The Care Closer to Home Strategy demonstrates the group's holistic approach to achieving this vision through integrated care commissioning. The strategy will support areas where care closer to home initiatives have already been implemented and areas identified for further opportunities. http://www.islingtonccg.nhs.uk/about-us/strategies/care-closer-to-home.htm
National Collaboration for Integrated Care and Support (May 2013) "Integrated Care and Support: Our Shared Commitment"	Presents a shared vision for integrated care and support to become the norm over the next five years. https://www.gov.uk/government/publications/integrated-care
"The NHS belongs to the People: A Call to Action" NHS E (July 2013)	Sets out the challenges facing the NHS and sets out that the NHS needs to change to meet that challenge. http://www.england.nhs.uk/2013/07/11/call-to-action/

2) VISION AND SCHEMES

a) Vision for health and care services

Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

Please describe the vision for health and social care services for this community for 2018/19.

Our vision for the Integrated Care Pioneer has underpinned our bid for the Better Care Fund. That is:

"To deliver a step change improvement in health and social care outcomes for our population, by taking a whole system approach to service planning and delivery and supporting the population to better manage their health through mobilising their own abilities and the assets of the community."

We have developed this vision for health and social care through listening to what patients and users have told us. They have said they want to be listened to and heard, to be treated as a whole person and for professionals to understand how disempowering being ill is. They want their care to be co-ordinated with better access to healthcare through social services and vice versa and they want to be supported to help them-selves. We have also heard how people don't always have positive experiences of our care services; that they can be confused by who is doing what and that care isn't always delivered in a way that shows compassion and maintains dignity.

We have also looked at our population to understand the health and care needs so that we can prioritise resource to make greatest impact. Islington is the 5th most deprived borough in London and the most densely populated borough in England. There is an unusual spatial distribution of affluence and poverty across the borough with rich and poor living cheek-by-jowl. The high level of deprivation is reflected in substantial inequalities in health and outcomes. Our Health and Wellbeing Board has identified four key priorities designed to drive system wide improvement.

These are:

- Ensuring every child has the best start in life,
- Preventing and managing long term conditions to extend both length and quality of life and reduce health inequalities,
- Improving mental health and wellbeing, and
- Delivering high quality, efficient services within the resources available

Islington has a long history of joint working and already has over £60m invested in pooled budgets. We welcome the Better Care Fund as an enabler to our work and to quicken the pace of change.

We want to see an improvement, not only in the outcomes of care but crucially in the

experience of care that is received and perceived by our residents.

What changes will have been delivered in the pattern and configuration of services over the next five years?

We have identified the key ingredients of our transformed service offer. We want to see:

An offer of **early intervention and prevention** for the whole population

Health and care systems and pathways that are **co-produced** with patients and users

Strong **clinical leadership** shaping and supporting change

Hospitals that **plan and support discharge** from the first day of admission

Better access to voluntary and community based services through **better information and advice**

Joined up care delivered through **four localities** based around GP practices

Better **identification and co-ordination** of patients/users at **high risk** of hospital admission

A programme of **supported self-management** for children and adults with long term conditions

More personalised service offers through the roll out of **personal health budgets** and increasing numbers of those who opt for a **personal budget**

Services that are more easily understood and accessed through **single point of access, single assessment processes** and **7 day working**

Better alignment **of physical and mental health services**

A **skilled workforce** that delivers care with dignity and compassion, is motivated to make a difference and is rewarded for its efforts

IT systems that support joined up care by becoming interoperable

If these key elements are delivered over the next five years we expect to have a health and social care offer that provides access to care at the right time, in the right place, in a co-ordinated and personalised way. Systems will be steam-lined, with pathways that reduce duplication, avoid unnecessary hospital admission and act swiftly to get people home and re-abled after illness. We also expect people to have a better experience of care and to feel like they have been given the information and advice they need to be informed of their condition and better able to manage by themselves or for those for whom they care.

To make this happen we are designing community services within four localities aligned around GP practices. We are likely to see some co-location of health and social care professionals to support more co-ordinated ways of working and opportunities for other partners such as housing and the voluntary sector to have space in which to operate.

Specialist services will remain borough wide but all health and social care professionals

will be able to access information about patients and users more easily within an ethos of holistic, compassionate care co-ordinated around the individual rather than reliant on current structures and professional boundaries. They will also be trusted to undertake a broader range of assessments on behalf of others and will be able to mobilise care packages when people need support to remain at home. Intrinsic to all care will be the ethos of supported self-care and personalisation so that users and patients can participate in planning their own care

Primary care will have developed new ways of working that is able to meet demand in a planned way, with opportunities for proactively planning and managing of care particularly for those with higher needs and long term conditions. Working within MDT's they will be able to support healthier communities through signposting to non-traditional services in the voluntary sector.

This is likely to mean that acute hospital provision reduces over time as care is provided in different settings and seven day access to primary and social care becomes available.

The Whittington, as the main provider of community services in the borough will have transferred staff and resource from the hospital into a broader offer of community provision with higher numbers of community and specialist nurses and therapists able to care for people at home. Consultants will be accessible to patients in new ways through an increased use of technology and will be outward facing providing support to primary and community colleagues.

Services will be designed to work proactively with patients and users able to mobilise quickly to avoid unnecessary emergency attendance at hospital and to reduce hospital admission. That means joint teams will work at the front line and in services like A&E to be able to put packages of care in place for people to avoid deterioration in condition or hospital admission.

Mental health professionals too will work more actively to support primary care in managing people's physical health needs and we want to see a reduction in health inequalities across the population as those that find it harder to access the right care are supported to do so.

Finally, access to information will be more streamlined with fewer telephone numbers and skilled staff able to triage and sign post effectively.

What difference will this make to service user and patient outcomes?

Through our joint efforts we want to see a population that has a better experience of health and social care services, feels more involved in decision making and is supported to manage their own care better.

We want to see a continued improvement in key metrics that measure health inequalities so that we know care is reaching all those that need it.

We also want:

- Improved reported quality of life for both carers and those who use social care services
- Improved patient reported outcomes and improvement in patient experience measures

- A reduction in long term admissions to care homes
- An increase in the proportion of older people at home 91 days after discharge from hospital
- Improved physical health outcomes for adults with a mental health diagnosis
- Retention of our excellent track record in delayed transfers of care
- Fewer hospital readmissions within 30 days
- Improved mortality from preventable causes
- Improved takeup of NHS health checks
- Increase in the uptake of personal budgets across health and social care

b) Aims and objectives
Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

Through securing the Pioneer status we hope to be able to scale up our efforts to integrate services and plan care around the individual. We have already referred to our vision, the ingredients of our approach and what our objectives are in bringing about change both at system level but also in patient and user experience.

Our aims for the programme are two fold; that we support the health and wellbeing at a population level whilst at the same time providing better co-ordinated care for more intensive users of services.

To support health and wellbeing for the wider population (Tier I and II) we will focus on three underpinning enablers:

- public and patient participation;
- mobilising the individuals' own abilities and motivations
- embedding health and well being

To continue to develop and co-ordinate the scale and responsiveness of care for more intensive service users (Tier III and IV) we will focus on the following population groups:

- older and vulnerable people
- people with long-term conditions
- people with mental ill health

As we are taking a life course approach to this work the health and wellbeing of children is integral to all work streams.

• How will you measure these aims and objectives?

We already collect a range of measures to help us understand how we are performing across the health and social care economy.

These include:

- Quality of life outcomes
- Patient reported outcomes
- Admissions to long term care
- Delayed transfers of care
- Length of hospital stay
- Numbers of those taking up personal budgets

However as part of the Integrated Care Programme we are seeking to develop a scorecard approach so that we can understand whole system impact.

• What measures of health gain will you apply to your population?

We will continue to measure mortality rates and plan to see a continued increase in smoking cessation rates.

Through our support planning approach we are developing person defined outcomes in order to measure success with MDT approaches.

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

We have started an ambitious programme of work already that is focussed on transformation of health and social care to deliver new integrated care systems. This programme aligns with existing CCG strategies around primary, planned and urgent care as well as the Joint Commissioning Strategy for Adults and our ongoing transformation of social care and support.

With these foundations in place we want to use 2014/15 to start building up a new infrastructure that can be scaled up and embedded in 2015/16. We acknowledge though that for integrated care to be sustained we must win hearts and minds as well as giving people the right tools and infrastructure. True transformational change will only come when new ways of working and the culture change has gained traction and we acknowledge that there are areas where change will be swift and others that are more iterative that will take many years to build up and flex as our environment changes.

2014/15

When thinking about how to use the Better Care Fund to support health and social care integration our starting position is to retain investment in those areas of social care that benefit health. These funding streams are already supporting joint work, for example, we have invested our re-ablement funding into the intermediate care pooled budget to ensure it is working to improve health and social care outcomes.

The other two schemes are central to the delivery of a new health and care offer, based around locality working and data sharing.

Scheme 1 – Social care investment to benefit health

Islington has already received investment for social care where there are clear benefits to health. This has been invested broadly and includes:

- Supporting the demographic pressure faced by both health and social care particularly in relation to older people and adults with learning disabilities
- The development of reablement capacity to enhance recovery and reduce length of stay
- The development of a reablement service focussed on adults with mental health needs
- The development of community enablement that uses and builds on assets within the community
- The development of the Council's telecare offer that has seen the use of telecare increase year on year
- The funding of a pooled budget for carer services able to invest in a Carers Hub as well as support flexibreaks and other support such as a Dementia Café

Joint commissioners remain active in reviewing this spend to ensure it supports our Integrated Care objectives and although much of it will remain supporting areas of mainstream activity we will have some focused review.

In 2014/15 we want to review the intermediate care pathway so that investment is aligned in the community where it can be most effective not only in reducing length of stay but also in developing rapid response functions that are more effective in hospital avoidance. Part of this review will be to ensure access 7 days a week for an extended day. We also want to ensure the community enablement capacity is sufficient to be able to support a more community asset based approach to supporting older people.

Patient activation and self care are areas of work where we want to further develop our offer. In 2014/15 we will consider how we can develop our offer around telecare and telehealth both to support professionals to work differently, for example, consulting via skype to using mobile devises or applications to support self care.

Bringing better alignment of physical as well as mental health services will help to support improved outcomes for adults with mental health needs. Similarly, working with children and young people in transition will continue in order to maximise independence and deliver personalised solutions that are sustainable long term.

Scheme 2 - Locality development

The key area of new work and investment using the BCF will be the development of the

locality offer. The work programme will include not only looking at what services will align with localities but also consider:

- The development of multi-disciplinary team working
- The expansion of teleconferencing to include those identified further down the triangle of risk
- Access arrangements including 7 day and extended hours
- Joint assessment processes
- Staffing capacity and skills mix
- Workforce development
- IT shared services
- Scope to share premises and co-locate services
- Ways of working including development of shared policies and procedures
- Development of a single point of access

We are proposing to allocate funding for pump priming as we know that there are likely to be double running costs to establish new models of working. There will also be recurrent investment to support the long term development of localities. Funding will be agreed through a process of business case development, sign off and evaluation. It will be open to all providers across the system to support innovation and change.

The Project Initiation Document for the locality development will be signed off by the end of March 2014 so the work can start in earnest from April.

Scheme 3 – IT interoperability

Work has commenced to scope out IT work streams such as:

- Information governance requirements including ASH and data sharing protocols
- Development of a patient accessible record
- IT interoperability between different health and social care systems

The Council has a project to ensure NHS numbers are included in user records so that we develop system wide identifiers. The CCG has applied for Accredited Safe Haven (ASH) status in order to be able to access patient identifiable data and has developed a clear set of data sharing agreements.

However, the provider IT landscape is complex, using different products that need to connect not only to those systems local to Islington but also those of other commissioners and providers. Furthermore, we need to be clear of how professionals are going to be working together in the localities in order to clearly specify what interoperability will be required.

Investment has been identified from the BCF to support this key enabling work stream.

Scoping documents have been developed and the next stage is to develop a Project Document that sets out the road map of delivery.

By the end of 2014/15 we hope to have in place an outline locality offer that is supported by providers and is clear to patients and those who use services.

We want person centred care to be becoming more of a reality as professionals and

others have become used to working together and co-ordinating around the individual. We also want to have started on the journey of culture change particularly in relation to consultation and supporting self-care so that care is developed in a person centred way.

We want to have started building up the community offer and see consultants coming out to support colleagues or seeing patients in community settings.

Workforce development and planning is a longer term strategy that will build up capacity over time. Similarly, we want to have IT systems that are able to support joint assessments even if there is further to go in terms of interoperability.

2015/2016

Our focus in 2015/16 will be to build upon our achievements in 2014/15 and to scale up integration across all areas of physical and mental health taking a life course approach so including children's services as well as adults.

In addition to the investment above there is a requirement to support the care and support reform introduced by the Care Bill so this will be detailed below.

Scheme 1 – Social care investment to benefit health

In addition to the funding set out in 2014/15 other funding streams will be brought into these arrangements including disabled facilities grant, adult social care community capacity capital grant and carers breaks funding.

Islington already has a pooled budget for carers' services so is in a good position to respond to these new requirements brought in under the Care Bill.

However, it is likely that with a shift to supporting more people at home we will need to increase investment in community based services such as home care as well as paying for more support via personal budgets.

Similarly social care investment in enhanced rapid response functions will need to increase if we are to support health colleagues in their goals of reduced readmission and reduced unplanned admissions.

Scheme 2 – Maintaining eligibility

Islington Council is proud of the fact that it has prioritised meeting moderate needs within the social care system. This supports the prevention offer and seeks to maintain people at home for longer by providing adequate care and respite.

As well as maintaining eligibility we will be investing the Better Care Fund in social care where demographic pressures are set to grow (older people and adults with learning disabilities).

Scheme 3 – Developing the locality offer

This will focus on Stage 2 of the development of localities. It will build on the infrastructure to expand the range of services that can be delivered closer to home particularly linked to pathway development. For example, we may wish to extend the

range of services delivered in the locality for people with diabetes.

We also want to ensure capacity has been built in the community and voluntary sector to support the universal offer.

Scheme 4 – Improving access to services

This will involve further streamlining of the single point of access and capacity building to deliver 7 day working across the social care and primary care.

Scheme 5 – Incentivising acute providers to deliver change

In order to retain a stable provider market Islington commissioners need to think through how to support the balance of provision across the whole system.

Scheme 6 - Develop primary care capacity to support locality approach

As well as workforce development we have identified that we will need to build capacity in the primary care sector if it is to respond to the challenge of providing care closer to home. This includes problems of recruitment and retention as well as premises large enough to support multi-disciplinary approaches.

Time frames:

January –March 2014

- January - draft plan to Integrated Care Board
- February – draft plan sign off by Health and Wellbeing Board
- March – final submission

April 2014 – March 2015

- April – investment and QIPP projects to support integrated care
- April - Launch project to develop locality offer
- April - Secure Accredited Safe Haven status and start development of specification for IT interoperability
- April - Launch workforce strategy in line with CEPN bid
- April – Actions to support the social care reform in Care Bill
- June – Expansion of MDT roll out
- October - Launch single point of access

April 2015-March 2016

- April – stage two of locality development

The integrated care programme is underpinned by the Joint Health and Wellbeing Strategy and is working to support the delivery of other key strategic documents such as the Joint Commissioning Strategy and Islington Primary Care Strategy.

The Integrated Care Board reports to the CCG's Strategy and Finance Committee. From here it reports through to the Governing Body and the Health and Wellbeing Board.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

Our vision for acute providers is that they will provide care for those who need it; plan for discharge from day one and have active services at the front door to avoid admission.

Islington CCG is the lead commissioner for Whittington Health Integrated Care Organisation. The majority of acute services are provided by Whittington Health and University College Hospital.

Since 2012 there has been a Transformation Board for the Whittington across the partnership of Islington and Haringey that seeks to support the development of the hospital into securing Foundation Trust status. As the Whittington also provides community services across the two boroughs it is in an excellent position to work with commissioners to support the delivery of our vision for integrated care.

Commissioners have been working with acute trusts to reduce hospital admissions, particularly readmissions, and A&E attendances. We want to see a continuation of this work as well as a focus on acute productivity to bring efficiencies within the local health economy.

The impact of the Better Care Fund will be;

- A locality offer that supports integrated discharge and rapid response to avoid unplanned hospital admission or readmission
- Intermediate care services that support early discharge and therefore reduce length of stay
- Alignment of community services and social care functions, like re-ablement, to support independence in the community
- IT infrastructure that supports shared care and less duplication
- An expectation that specialists working in acute hospitals will be outward facing and able to support community colleagues
- Acute trusts that focus on reducing unplanned admissions through ambulatory care, early supported discharge and services like RAID to support adults with mental health needs

In terms of savings:

- Acute productivity will lead to realised contract efficiency
- Development of a community offer will reduce unplanned admissions
- Ambulatory care services are expected to see a reduction in admission that will lead to contract reduction
- Oversight of data at system wide level will enable clear oversight of spend

Failure to deliver will lead to:

- Continued pressure on CCG and Council budgets

- Continued risk to acute's ability to manage peaks in emergency attendances and admissions
- Opportunities to invest in community and primary care will be compromised.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

Proposed governance in brief:

Governance within the CCG will be through quarterly S256 review meetings held jointly with the Council; regular review through the Integrated Care Board; six monthly reports to the Finance and Strategy Committee and annual reports to the Governing Body.

Governance within the Council will be through quarterly S256 review meetings (above); review through the Integrated Care Board; annual report to the Executive.

The Health and Wellbeing Board will receive six monthly reports on the plan.

3) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

Islington is proud of its history in protecting social care for those who need it and maintaining eligibility levels to ensure those with moderate needs and above are supported to live independently in the community.

We have seen demand rising at a time of budget pressure and have been keen to maintain an emphasis on personalisation, prevention and early intervention. This is backed up by a strong public health offer and investment in universal services which are delivered through a rich diversity of voluntary sector provision.

For those who need care we have built on the legacy of joint working to make sure that we optimise effort and spend through collaboration with partners. Our focus of this joint work has been to deliver more pro-active interventions using a recovery model so that we can intervene early and maximise independence. Our integrated care programme supports this vision for social care with an emphasis on better information and advice at a population level and co-ordinated care delivered for those who need it, with a focus on re-ablement and recovery.

Please explain how local social care services will be protected within your plans.

Islington has developed Section 75 pooled budgets as well as used Section 256 transfers to support the development of a strong social care offer. We plan to continue this way of working with the added requirement of supporting the new social care reforms including the development of a seven day offer.

We are using the Better Care Fund to support demographic pressure, to maintain eligibility and to support the additional demand for information and advice that we expect to see as a result of the new Care Bill.

We also want to invest in our locality offer which is likely to see an increase in demand for domiciliary support for those who are cared for at home as we reduce the numbers of those in hospital or in long term care institutions.

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

Our locality offer will build upon the current seven day services that are already available across health and social care to ensure that there is a robust offering that is equitable and responsive.

We already have seven day working and response from reablement, with in-reach to acute hospitals, and strong links to the FEDS therapies team to identify people who could go home with reablement support. We have run a pilot over the winter with a social worker on site at both hospitals and want to use the evaluation of this to inform the model for social work access over seven days.

We also want to quantify more clearly what the additional funding requirement is, although we plan to use the Better Care Fund to pump prime the offer. From experience at the Whittington where acute therapists were moved to seven day working it did require additional resource, partly because we still needed the same level of staffing during the week (more or less) to respond to demand, mobilise patients etc. and partly because of the enhanced payments for unsocial hours. The change there also included extended hours for the FEDS (Rapid response in ED) team, so that there is an 8.00 - 8.00 service. This expansion to seven day working did produce benefits such continuity of therapy input, support for the enablers e.g. so that people don't 'seize up' if discharged prior to weekend and not moving about or get reassurance if they are struggling. Also there was more interaction with families who may work during the week.

This offer will be developed as part of our locality approach with primary care colleagues who have already started to consider how they may collaborative to provide extended hours services.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

All health and care systems will use the NHS number as an identifier from 2014/15. Islington Council has a programme of work currently underway to upload NHS numbers onto social care records.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

N/A

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK))

Our work programme covering information governance and IT interoperability will ensure that we are adopting systems that are based upon Open API's and open standards. We already have security systems in place including the use of GCSX email.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

We are developing clear protocols and data sharing agreements across systems to ensure information Governance requirements are met. The CCG has applied for Accredited Safe haven Status.

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

Part of the process towards delivering Integrated Care is the identification of people who require varying levels of support from health, social care and/or voluntary sectors. It is estimated that there are over 40,000 people in Islington living with either one or more long term conditions. In order to achieve a better understanding of the population health and social care need it is recognised that the best approach is through risk stratification. Islington CCG researched and reviewed documentation in relation to national pilots of risk stratification tools, as well as other areas of health stratification; it discussed options with other local health economies and obtained information from private industry.

After careful review of the market, it was decided that since the CCG had sufficient in house expertise, it would develop its own risk stratification tool. The tool was developed in house and launched in September 2012 as the PIT (Patient Identification Tool). This tool was used over the course of 2013 to identify patients for referral to the multi-disciplinary team tele-conferences. A set of criteria were developed to highlight patients who might be expected to be at risk of hospitalisation and would therefore be appropriate for discussion by a multi-disciplinary team. Over 350 patients have been through this process over the last 12 months.

In August 2013 the tool was further developed by colleagues in public health and informatics to make it more predictive. It was recognised that the leader in the field was the Nuffield Trust and their tool was used as a guide to develop the risk stratification element of the PIT. The tool that Islington now uses has a similar sensitivity and specificity to the Nuffield Trust, but is more locally focussed.

The predictive PIT was launched in September 2013 and was used in the first instance to provide lists of high risk patients which were sent out to all Islington practices as directed by the Risk Profiling Directed Enhanced Service (NHS England). The DES requires practices to analyse lists of patients who have been highlighted as having greater health and social care needs and bring the selected patient cases to an in house MDT meeting for discussion and referral for care planning, either within the practice or with community services (community matron, social services, mental health, etc.). The more complex patients are referred to the locality based MDT tele-conferencing where a wider MDT team can provide input.

Currently the use of the tool is limited by the information governance directives; however Islington is anticipating that it will be granted Accredited Safe Haven (ASH) status in the very near future and this will enable the tool to be used in a much more meaningful way.

Islington intends to use the tool to develop its understanding of the overall health of its

population. The stratification of the population will be cut at different levels of risk, by demography, locality, disease condition, etc. allowing health and social care professionals to direct services accordingly, identify gaps in service provision, inform commissioning and support the development of the integrated care locality offer.

It is expected that one of the areas of most benefit from use of the PIT will be the tier 2/3 patients who are currently low/moderate users of health and social care. Identifying them at a lower level risk allows the opportunity to provide greater input within the community to prevent them from becoming more unwell and being admitted to secondary care.

Use of the PIT is a key element of the development of the locality service redesign as it will provide the opportunity to analyse need at a locality level (and at individual level within the locality) so that services can be designed accordingly.

4) RISKS
Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	Risk rating	Mitigating Actions
Our plans are predicated on the understanding that increased investment in social care and community services will be matched by a reduction in use and therefore cost in the acute sector. The risk is that acute activity continues at a rate that makes the financial shift unlikely in the longer term.	M	Financial modelling across the whole system is to be commissioned in order to inform a QIPP plan and acute contract models
Acute providers are destabilised by shifts of resource to the community.	L	Whittington ICO is on our Integrated Care Board and is actively working with us to understand how the shift of care can be achieved within their current business plans.
Locality development is as much about culture change in the workforce as organisational structure. The risk is that our approach fails to motivate frontline staff who continue working in traditional ways.	M	We are developing a joint workforce development strategy and have identified leads in the key organisations to support culture change.
IT interoperability is a key enabler for multi disciplinary team working – without it staff are using workarounds or double entry which is inefficient and not sustainable longer term	M	As Pioneers we are working with other London boroughs and with national agencies to specify requirements for IT interoperability so that we can target investment well.
Capacity within health and social care means we can't deliver at the pace that we have set ourselves.	L	As Pioneers we have set up clear governance arrangements between the CCG and the Council that oversees the programme.

		We have also invested in programme management support.
Patients, service users and carers continue to experience poorly co-ordinated services that are not designed around their needs and the outcomes they want to achieve for themselves	M	We have set up the Making it Real Board where we hope to have input into the design of new ways of working, as well as a forum for feedback and evaluation.